



DEPARTMENT OF THE NAVY

BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

BUMEDINST 6010.17B
BUMED-M3MB
7 Mar 2003

BUMED INSTRUCTION 6010.17B

From: Chief, Bureau of Medicine and Surgery

Subj: NAVAL MEDICAL STAFF BYLAWS

Ref: (a) DOD Directive 6025.13 of 20 Jul 1995
(b) Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Accreditation Manual for Hospitals (NOTAL)
(c) JCAHO Accreditation Manual for Ambulatory Care (NOTAL)
(d) SECNAVINST 6401.2A
(e) BUMEDINST 6320.66C
(f) BUMEDINST 6320.67A
(g) BUMEDINST 6010.13
(h) BUMEDINST 6010.18A
(i) Manual of the Medical Department, Chapter 16
(j) BUMEDINST 6010.21
(k) DOD Directive 6040.37 of 9 Jul 1996
(l) ASD(HA) policy memo 98-031 of 15 Apr 1998
(m) OPNAVINST 6320.7

Encl: (1) Naval Medical Staff Bylaws
(2) Naval Medical Department Facility-Specific Medical Staff Policies and Procedures - Suggested Outline
(3) Naval Medical Department Facility-Specific Medical Staff Policies and Procedures for Restraint and Seclusion - Suggested Outline

1. Purpose. To provide medical staff bylaws for Department of the Navy (DON) fixed medical treatment facilities (MTF), per references (a) through (c). References (d) through (l) provide additional guidance. These bylaws constitute a framework in which medical staff members may act with a reasonable degree of freedom and confidence for self-governance of professional activities and ensure accountability to the governing body. This instruction has been completely revised and must be read in its entirety.

2. Cancellation. BUMEDINST 6010.17A.

3. Applicability. This instruction applies to all active duty and Reserve military and civilian health care practitioners, as defined in reference (e), who are assigned to, employed by, contracted to, or under partnership agreement with DON activities that are required by reference (a) to seek accreditation by JCAHO under references (b) or (c). The operational forces, while exempt from the JCAHO accreditation requirement, must establish and implement comparable quality of care oversight mechanisms for operational medical units as required by references (a) and (m).

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a. All DON health care practitioners who are responsible for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical care must be subject to credentials review and must be approved for delineated clinical privileges by a designated privileging authority before independently providing patient care per reference (e). Clinical privilege approval and medical staff appointment are required for those practitioners assigned to an MTF.

b. Per reference (e) clinical support staff, while required to be educationally qualified and currently competent to provide health services, are not authorized to provide care independently, are not eligible to participate in the privileging process, and are therefore not eligible to be members of the medical staff.

4. Medical Staff Bylaws

a. Navy Medical Department rules and regulations relating to medical staff appointment with clinical privileges and adverse professional actions are contained in references (e) and (f).

b. Navy Medical Department guiding principles can be found at: <http://bumed.med.navy.mil/meddept.pdf>.

c. Naval Medical Department medical staff bylaws required by reference (b) are contained in enclosure (1). Individual commands shall not unilaterally modify these bylaws.

d. MTF-specific medical staff policy and procedures must be recommended by the MTF Executive Committee of the Medical Staff (ECOMS) and approved by the MTF privileging authority as designated by reference (e). Enclosure (2) is a template for local medical staff policies and procedures. Neither the ECOMS nor the local privileging authority shall unilaterally modify the MTF-specific medical staff policies and procedures.

e. Facilities must adhere to current, applicable JCAHO standards in matters that are not specifically addressed in enclosure (1).

5. Responsibilities

a. Per reference (d), the Chief, Bureau of Medicine and Surgery (BUMED), under the Chief of Naval Operations, is responsible for technical professional evaluation and execution of the credentials review and privileging program, including the Naval Medical Department medical staff bylaws.

b. Commanding officers must ensure that the medical staff under their cognizance:

(1) Comply with enclosure (1).

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(2) Develop local facility policies and procedures that address the issues identified in enclosures (1) through (3), required by references (b) and (c), as applicable.



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Vice Chief

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NAVAL MEDICAL STAFF BYLAWS

1. General. These bylaws are effective on the date of this instruction. All members of the medical staff per reference (e) are subject to these bylaws and to locally developed supplemental MTF medical staff policies and procedures. Both are subject to review as part of the MTF's Quality Management (QM) Program.

a. Organization of the Medical Staff. Each MTF must establish local policies and procedures describing the organization of the medical staff, including a description of medical staff officer positions, the method of selecting officers, the qualifications to hold an office, responsibilities and tenures of officers, and the conditions and mechanisms for removing officers from their positions. All officers of the medical staff, including committee chairs, must be members of the medical staff and must be appointed by the commanding officer or elected by the medical staff. At least one member shall be elected to the ECOMS by the medical staff. The ECOMS makes appointment recommendations regarding office candidates to the commanding officer who has final decision authority. The commanding officer may remove any appointed or elected officer or chair in a "show cause" or per paragraph 6a(3) of this enclosure.

b. Each current member of the medical staff and each applicant for appointment must be oriented to these bylaws and supplemental MTF medical staff policies and procedures. Practitioners must agree in writing that the provisions set forth in the medical staff bylaws bind their activities as members of the medical staff.

c. Each current member of the medical staff and each applicant for appointment must receive a copy of, or have ready access to, a copy of these bylaws and the supplemental MTF medical staff policies and procedures.

d. All MTF practitioners must be notified in writing and provided a copy of, or have ready access to, the revised text when significant changes are made in these bylaws or supplemental MTF medical staff policies and procedures.

e. There must be medical staff representation and participation in any MTF deliberation that affects the discharge of medical staff responsibilities.

2. DON Medical Staff Membership

a. DON Medical Staff. All privileged practitioners assigned to, employed by, contracted to, and under partnership agreement with DON MTFs constitute the DON medical staff, to include physicians with Doctor of Medicine or Doctor of Osteopathic Medicine degrees, dentists, advanced practice nurses, and allied health specialists. Telemedicine providers for DON MTFs are not required to be members of the medical staff at the receiving MTF. The local medical staff is a subset of the DON medical staff and must meet the following criteria:

(1) Licensed Independent Practitioners (LIPs). Must be privileged practitioners as designated by references (a) and (e) to provide patient care services independently in MTFs to the degree permitted by a license, training, the law, or DON regulations.

Enclosure (1)

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(2) Delineated Clinical Privileges. Must be granted to define the scope of patient care services that may be provided independently to the degree permitted by a license, training, the law, facility limitations, and DON regulations (see paragraph 4).

b. Medical Staff Appointment Categories. A medical staff appointment is a formal, written authorization to perform patient care with delineation of clinical privileges, reflecting the relationship of the practitioner to the medical staff. It will be extended only to competent professionals who continuously meet the qualifications, standards, and requirements set forth in these bylaws, and associated policies of the medical staff and the Navy. The medical staff is organized under Department of Defense (DOD) policy guidelines for medical staff appointments and privileges. There are four categories of medical staff appointments, per reference (e):

(1) Initial Staff Appointment. The initial Naval Medical Department professional staff appointment gives the practitioner the opportunity to demonstrate to the privileging authority current clinical competence and the ability to comply with the facility's policies, procedures, bylaws and code of professional ethics. The initial staff appointment period will be a length of time in which the applicant meets all the criteria for active staff appointment not to exceed 12 months. The initial appointment may lead to an active or an affiliate staff appointment.

(2) Active Staff Appointment. Staff appointments granted to practitioners who successfully complete the initial staff appointment period. The active staff appointment period is 24 months. Active staff members are expected to participate fully in medical staff activities and abide by all medical staff bylaws.

(3) Affiliate Staff Appointment. Granted to practitioners meeting all qualifications for appointment to the medical staff after successfully completing the initial appointment period, but who are neither assigned organizational responsibilities nor expected to be full participants in activities of the medical staff. The affiliate staff appointment period does not exceed 24 months. Affiliate members must be knowledgeable of and agree to abide by the medical staff bylaws.

(4) Temporary Staff Appointment. Temporary appointments are granted in situations when time constraints will not allow full credentials review. Use of temporary appointments should be infrequent and only to fulfill pressing patient needs. Temporary appointments are required when practitioners practicing under temporary privileges will be admitting patients. Temporary appointments may be granted only after the facility has primary source verified licensure and current competence. The appropriate department head, chair of ECOMS, and privileging authority, must endorse them. Temporary appointments are granted not to exceed 30 days, per reference (e).

c. Privileging Authorities. Within the Navy Medical Department, each MTF medical staff is organized under a privileging authority, per reference (e), who also serves as the local governing body representative. The medical staff is responsible for the quality of the medical and dental services delivered by practitioners in the facility and is accountable to the privileging authority. The privileging authority for Naval Reservists is the Officer in Charge, Healthcare Support Office (HLTHCARE SUPPO), Jacksonville, Florida.

3. Appointments and Reappointments. Appointment and reappointment to the medical staff will be made upon recommendation of the MTF ECOMS and approval by the privileging authority, per reference (e).

a. Criteria for Medical Staff Appointment. Medical staff appointment and reappointment criteria have been adopted to ensure that appropriately trained and highly competent medical staffs are available to provide health care services per reference (e). The criteria must be uniformly applied to all applicants, including those in administrative positions who are eligible for medical staff appointment. The following criteria form the basis for granting appointment to the medical staff:

(1) The practitioner possesses current licensure; relevant training and experience; appropriate peer, directorate, department, or division head recommendation; and current competence in the requested privileges. The professional license must be current (active, not revoked, suspended, or lapsed in registration), valid (the issuing authority accepts, investigates, and acts upon quality assurance information such as practitioner professional performance, conduct, or ethics of practice regardless of the practitioner's military status or residency), and unrestricted (not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction).

(a) Primary source verification is performed, per reference (e), in the multi-institutional credentials review and privileging process.

(b) Action on an application for initial or renewal appointment with clinical privileges will not proceed until the required information is available and verified.

(c) Other sources of information about applicants, such as the American Medical Association Physician Masterfile and the Federation of State Medical Boards Physician Disciplinary Data Bank will be considered when available.

(2) The practitioner has no current mental or physical impairment that could limit the practice of requested privileges.

(3) Suitable facility, staff, support services, and appropriate equipment are present for the applicant and the applicant's patients.

(4) The need exists for additional staff members with the applicant's skill and training to meet the needs of the patient population served.

(5) The practitioner possesses current evidence of adequate professional liability insurance when required.

(6) The practitioner participates in relevant continuing professional education that relates, in part, to the privileging granted.

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(7) Reappraisal for reappointment to the medical staff and renewal or revision of clinical privileges will be based on information from the individual's professional performance (performance appraisal report), judgment, and clinical and technical skills, including the results of QM activities.

(8) Results of a National Practitioner Data Bank query will be used in evaluating the applicant, per reference (h).

b. Gender, Race, Creed, or National Origin will not influence decisions on granting or denying staff appointment or reappointment with clinical privileges.

c. Application Process. The medical staff must possess adequate information for a conscientious evaluation of the applicant in order for the ECOMS to make a recommendation to the privileging authority concerning an applicant for appointment or reappointment to the medical staff or for modification of clinical privileges. Accordingly, the medical staff will not act on an application that is not complete. An application for appointment, reappointment, or modification of clinical privileges shall not be deemed complete unless the following are met:

(1) Submission of a written application, per reference (e), in which all of the requisite information is provided. All entries and attachments must be legible, understandable, and substantively complete on every point of inquiry.

(2) Applicant responds to all further requests for clarifying information or submission of supplementary materials from the medical staff and/or the professional affairs coordinator (PAC).

(3) Application for new or additional privileges by a medical staff member in good standing shall be submitted complete with supporting documentation to qualify for the requested privileges.

(4) Incomplete applications will not qualify for an appointment recommendation. Should a practitioner fail to make the application complete after a reasonable opportunity to do so, the application will be deemed withdrawn and the credentials process will be terminated. Termination of the credentials process under this provision shall not entitle the applicant to any hearing or appeal. ECOMS will be notified before any action is taken to terminate application.

(5) Practitioner keeps the application current and complete by informing the PAC in writing of any material change in the information provided or new information that might reasonably impact the applicant's candidacy.

d. Application for Medical Staff Appointment. Each applicant for medical staff appointment must submit a complete application per reference (e) containing the following disclosures:

(1) Any past or current involvement in a professional liability action filed and served on the applicant.

(2) Any past or current involvement as a defendant in a felony or misdemeanor case.

(3) Any voluntary or involuntary termination of medical staff appointment (membership); or voluntary or involuntary withdrawal, revocation, reduction, suspension, denial, or loss of staff appointment or clinical privileges at another MTF.

(4) Any previously successful or currently pending challenges (including suspension, revocation, and restriction) to any licensure, registration, or certification (State, district, or Drug Enforcement Administration (DEA)), or the voluntary relinquishment or restriction of such licensure, registration, or certification in any jurisdiction.

(5) Any involvement in the unlawful use of controlled substances.

(6) Past or current treatment for an alcohol or drug-related condition.

(7) Past or current treatment or formal therapy for a mental health condition.

(8) Recent (past 5 years) hospitalization history.

(9) Current physical or mental impairment, current medications, and the presence of any potentially communicable disease or known positive serum hepatitis B surface antigen that could limit clinical practice.

(10) Each applicant must:

(a) Consent to inspection of records and documents pertinent to his or her licensure, specific training, experience, current competence, and ability to perform (health status) and appear for an interview when requested.

(b) Submit reasonable evidence of current health status when requested by the ECOMS.

(c) Submit a signed statement pledging to provide for the continuity of care of his or her patients.

(d) Agree to provide to the medical staff updated information requested on the original application and subsequent reapplications or privilege request forms.

e. Privileging authority action on complete applications must be accomplished within 90 days. The processing of application packages will not begin until the package is considered complete per paragraph 3d of these bylaws. See paragraph 2b of these bylaws for appointment categories and duration.

f. Practitioners must be advised, in writing, by the privileging authority when medical staff appointment is granted.

g. A separate individual credentials file must be maintained for each medical staff member.

4. Delineated Clinical Privileges. Clinical privileges must be related to an individual's documented experience in specific treatment areas or procedures, including the results of treatment and the conclusions drawn from QM activities when available. Board certification, education, training, ability to perform, and current competency will be considered when delineating clinical privileges. When privilege delineation is based primarily on experience, the individual's credentials record must reflect the specific experience and successful results that form the basis for the granting of privileges. The process for the delineation of clinical privileges is described in reference (e). The privileging authority is responsible for the final decision based on the medical staff's recommendations regarding an individual's appointment or reappointment to the medical staff and granting of regular or temporary clinical privileges (defined in reference (e) and below).

a. All practitioners who are eligible to provide patient care services independently must apply for and be granted delineated clinical privileges consistent with the medical staff appointment criteria in these bylaws.

(1) Temporary Clinical Privileges. Temporary clinical privileges may be granted in situations when time constraints do not allow a full credentials review. Granting of temporary privileges should be rare, and only to fulfill pressing patient care needs. Temporary privileges may be granted with or without a temporary appointment to the medical staff. They are granted only after the facility has primary source verified licensure and current competency (a documented telephone call is acceptable). The appropriate department head, chair of ECOMS, and privileging authority, must endorse them. Temporary privileges do not guarantee a staff appointment and are not to exceed 30 days.

(2) Command Consultant Privileges. Consultant privileges are not granted within the DOD policy guidelines for medical staff appointment and privileges. These practitioners must be granted a medical staff appointment and/or clinical privileges consistent with these bylaw policies.

b. The delineation of a practitioner's clinical privileges must include any limitations to admit, treat, or direct the course of a patient's treatment.

(1) Patients admitted for inpatient care must have a medical history taken and an appropriate physical examination performed by a qualified practitioner with the appropriate admission privileges who is also a member of the medical staff. Only members of the medical staff shall be granted privileges to independently admit to inpatient services.

(2) DON allopathic and osteopathic physicians who are members of the medical staff with clinical privileges, while not specifically listed in each core privilege list, by virtue of licensure and medical staff status, are authorized to admit patients to inpatient services. Naval Medical Department facility-specific medical staff policies and procedures, enclosure (2), will delineate exceptions to the bylaws based on facility limitations.

(3) Nonphysician LIPs (members of the medical staff) may perform all or part of the admission medical history and physical examination if granted such privileges. The findings, conclusions, and assessment of risk are confirmed or endorsed by a qualified physician prior to major high-risk diagnostic or therapeutic interventions as defined by the local medical staff. This requirement for prompt medical evaluation by a qualified physician does not apply to qualified oral-maxillofacial surgeons or other LIPs who have been granted the clinical privileges to perform a history and physical examination in their specialty.

(4) The role of the medical staff must be clearly defined in the written plan for the care and appropriate referral of patients who are emotionally ill, who become emotionally ill while inpatients, or who suffer the results of alcoholism or drug abuse except in MTFs with psychiatric or substance abuse departments. The policies and procedures of each MTF will delineate the referral or transfer process of patients in circumstances when required services are not provided by the facility, for example, emotional illness or substance abuse.

(5) The general medical condition of each patient admitted is the responsibility of the admitting practitioner who must be a member of the medical staff.

(6) Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry.

(7) Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry.

(8) Specific admission privileges must be granted to any nonphysician practitioner.

c. Life-Threatening Emergency. Any practitioner is permitted to do everything possible within the scope of his or her license and regardless of staff status or clinical privileges to save a patient's life, to save a patient from serious harm, or to prevent serious deterioration or aggravation of a patient's condition, per reference (e).

5. Adverse Privileging Actions. Procedures for fair hearing, appellate review, and corrective action are in reference (f). Appropriate action, that includes a peer review panel hearing, will be taken when the review of credentials and the recommendations regarding staff appointments or clinical privileges are adverse to the applicant, per reference (f). Adverse privileging actions will be reported to the National Practitioner Data Bank, per reference (h).

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6. Organization of the Medical Staff

a. ECOMS. Privileging authorities of MTFs will appoint an ECOMS that is empowered to act for the medical staff. The ECOMS participates in each MTF deliberation on the discharge of professional responsibilities. The committee is delegated the primary authority over professional services and QM activities provided by practitioners with clinical privileges.

(1) Membership Eligibility. All members of the medical staff are eligible for appointment or election to the ECOMS. A medical staff member actively practicing cannot be considered ineligible based solely on the professional specialty or discipline. The medical staff will make recommendations to the privileging authority (e.g., commanding officer or commander) regarding final appointment nominees of ECOMS members. At least one member shall be elected to the ECOMS by the medical staff.

(2) Membership Period. Initial appointment and renewal of appointment to the ECOMS shall not exceed a 24-month period per appointment.

(3) Membership Termination. ECOMS membership automatically terminates upon revocation, suspension, or reduction of clinical privileges for reasons related to conduct or professional performance, listed in reference (f), or for other reasons at the discretion of the privileging authority.

(4) Membership and Voting Status. A majority of voting members must be fully licensed physician members of the medical staff. Membership must include the physician advisor for QM and the chair of the credentials committee when a separate committee exists. The remaining minority membership will reflect the clinical diversity of the nonphysician medical staff. Nonmedical, nonvoting staff members may be appointed to the ECOMS.

(5) Small Facilities. The medical staff as a whole may serve as the ECOMS if the medical staff consists of no more than 15 members.

(6) Meeting Frequency, Minutes, and Attendance

(a) The ECOMS may meet as often as necessary, but no less than quarterly to maintain effective communication among the medical staff, hospital administration, and the governing body. ECOMS meeting intervals must allow for the expeditious management of credentials packages. Peer review activities with subsequent action must be timely, i.e., dealt with at the time of occurrence, and not delayed until the next scheduled ECOMS meeting. Each member of the ECOMS must attend at least 75 percent of all scheduled meetings per calendar year to remain eligible for continued membership on the committee. For quarterly meetings, members must attend at least three meetings (75 percent) to remain eligible for continued membership on the committee. A majority of ECOMS voting members present must be fully licensed physician members of the medical staff actively practicing in the facility.

(b) The medical staff as a whole may meet as often as necessary to fulfill its responsibilities of monitoring, evaluating, and improving care within the facility and for the effective performance of the staff functions specified in these bylaws. Each facility will establish mechanisms to provide for effective communication among the medical staff and all levels of governance involved in policy decisions affecting patient care services. A summary of any formal communications shall be forwarded to the ECOMS reflecting medical staff needs and concerns.

(7) Responsibilities of the ECOMS. The ECOMS is responsible for making recommendations directly to the privileging authority per references (b) and (e) for approval on at least the following matters:

(a) Structure of the professional staff.

(b) Reviewing, granting, reducing, revoking, suspending, denying, or terminating a practitioner's appointment to the professional staff and delineated clinical privileges, policies, and procedures, per references (e) and (f). When privileging action on nonphysician practitioners is considered by the ECOMS, a peer of that practitioner must be present and involved in the dialogue.

(c) Organization of medical staff QM activities, including the mechanism used to conduct, evaluate, and revise such activities. A primary goal of QM activities will be to ensure the same quality of care throughout the organization.

(d) Mechanisms for peer review and fair hearing procedures and the mechanism which medical staff may terminate appointment, consistent with reference (f).

(e) Reviewing and acting on reports and recommendations from medical staff committees, clinical directorates or departments, process action teams, and other assigned activity groups.

(f) Reviewing an annual evaluation of the effectiveness of the medical staff's participation in QM activities that is also included in the annual appraisal of the facility's QM Program, per reference (g).

(g) Adoption or amendment of local policies and procedures of the medical staff subject to the approval of the local representative of the privileging authority. Such policies and procedures must be developed with due regard for ensuring quality patient care by all individuals with delineated clinical privileges within and across directorates and departments.

(h) Disseminating information from medical staff meetings to facility medical staff, clinical support staff, administration, and the privileging authority, per references (e) and (g). The medical staff may communicate with all levels of governance involved in policy decisions affecting patient care services within the Navy Medical Department via the chain of command and the appropriate specialty advisor.

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(i) Recommending space and other resources, e.g., categories and numbers of practitioners, needed to support the facility's overall plan for care delivery.

b. Clinical Departments. In facilities with medical staff departments, local MTF policies and procedures will specify a meeting frequency for clinical departments, no less than quarterly, at which time the findings of QM activities will be reviewed. Meetings will be documented, per references (b) or (c), as applicable, and references (e) and (g). Summary of findings will be presented to the ECOMS quarterly. These activities are the responsibility of the entire medical staff in a facility with a nondepartmentalized medical staff.

(1) All individuals with delineated clinical privileges must be assigned to and have clinical privileges in at least one clinical department when medical staff clinical departments exist. Reference (e) provides guidance for the granting of clinical privileges in more than one department or clinical specialty area. MTFs will have local policies and procedures to address the medical staff mechanisms for the recommendation of privileges and QM activities involving all individuals with clinical privileges when there are no medical staff departments.

(2) Responsibilities of Department Heads (Chairs, Service Chief, or Other MTF-Specific Designation). The commanding officer or commander appoints department heads. A non-physician medical staff member with clinical privileges may be appointed department head of a clinical department. In that case, peer review monitoring of clinical competency, staff appointment, and privileging issues should include review by the appropriate professional specialty. Department heads must be certified by a specialty nursing, medical, or allied health specialist board, and affirmatively establish their current competence through the privilege delineation process. Department heads provide effective leadership and efficient management in the following areas:

(a) Oversee all clinical and administrative activities within the department.

(b) Ensure professional performance is evaluated for all individuals who have delineated clinical privileges within the department.

(c) Recommend to the ECOMS the departmental-specific criteria for all clinical privileges in the department, including supplemental and itemized, per reference (e).

(d) Recommend clinical privileges for each member of the department. Exercising clinical privileges is subject to the rules and regulations of that department and to the authority of the department head based on the practitioner's scope of practice as permitted by their license, current level of training, current clinical competence, and ability to perform privileges granted.

(e) Oversee continuous measurement, assessment, and improvement of care and services provided. The medical staff must have in place mechanisms designed to:

1. Involve members of the medical staff in activities to measure, assess, and improve system performance.

2. Communicate the findings, conclusions, recommendations, and actions taken to improve system performance to appropriate members of the medical staff.

3. Determine the use of relevant practitioner performance assessment findings in peer review and periodic evaluations of LIP competence, per the "Medical Staff" chapter of reference (b).

(f) Integrate the department into the primary functions of the organization.

(g) Coordinate and integrate interdepartmental and intradepartmental services.

(h) Develop and implement policies and procedures that guide and support the provision of services.

(i) Determine and recommend the resources necessary for safe patient care and additional services.

(j) Determine the qualifications and competence of department personnel who are not LIPs and who provide patient care services.

(k) Maintain quality control programs, as appropriate, in the areas of clinical laboratory services, diagnostic radiology services, dietetic services, nuclear medicine services, and radiation oncology services. Quality control programs will not be limited to these services, but will be part of a larger program of ongoing measurement to assess the stability of a broad range of clinical processes.

(l) Orient and continually educate all persons in the department.

(m) Assess and recommend to the relevant MTF authority concerning space and other resources that are needed for patient care services, but are not available in the department or the MTF.

(n) Specify the mechanisms by which clinical support staffs are supervised by members of the medical staff in carrying out their patient care responsibilities.

c. Basic Medical Staff Responsibilities. Each member of the medical staff is required to notify the privileging authority, through the professional affairs department, whenever:

(1) Formal proceedings by a licensing authority or the DEA are initiated, including the filing of an accusation or complaint, to suspend, revoke, or place on probation a license, certification, or a DEA certificate.

(2) The ECOMS or the governing body of another MTF recommends the member's clinical privileges be suspended, revoked, or denied for reasons related to professional competence or conduct.

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(3) The member develops a mental or physical condition or other situation that could significantly compromise his or her ability to perform the functions associated with clinical privileges.

7. Special Treatment Procedures. These interventions require a special sensitivity to patient rights and risk management issues. Policies and procedures for the use of these special interventions are developed through an interdisciplinary process and approved by the ECOMS. MTFs will develop local policies and procedures to provide guidance on the use of special treatment procedures in all areas of the facility. Use of these procedures must be documented in the medical record. Local policies and procedures must address the following special treatment procedures whenever applicable to the facility (see enclosure (3) for more detailed guidance):

- a. Restraint or seclusion.
- b. Electroconvulsive or other forms of convulsive therapy.
- c. Psychosurgery or other surgical procedures to alter or intervene in an emotional, mental, or behavioral disorder.
- d. Behavior-management procedures that use aversive conditioning to manage or improve an individual's behavior.
- e. Substance abuse services.

8. Quality Management (QM). A goal of QM is the continuous improvement of patient health outcomes while improving access and reducing cost. QM activities will include the guidelines in references (b) and (c). These references list a number of important functions that include: leadership, management of information, human resources, the environment of care, governance, surveillance, prevention and control of infection, improving organizational performance, patient rights, organizational ethics, assessment and care of patients, education of patients and family, and the continuum of care. Each function must be the focus of measurement, assessment, and prioritized improvement activities.

a. Participation of the Medical Staff. The medical staff must participate in QM activities that are carried out collaboratively throughout the organization across multiple, structural, and staffing components involving the appropriate departments and disciplines as part of the facility's QM Program. The primary focus in improving performance will be on the organization's systems and processes rather than on the performance of individuals. While most opportunities for improvement come from process weaknesses and not individual incompetence, there is still a need for assessing individual competence and performance, including peer review.

b. Dimensions of Performance. Performance is what is accomplished and how well it is carried out to provide health care. Characteristics of health care performance are called

dimensions of performance. The level of performance in health care is the degree to which it is available in a timely manner and is safe, efficient, effective, safe, caring and respectful of the patient, and continuous with other care and care providers.

(1) Doing the right thing

(a) The degree to which the care of the patient has been shown to accomplish the desired or projected outcome(s).

(b) The degree to which the care provided is relevant to the patient's clinical needs given the current state of knowledge.

(2) Doing the right thing well at the right place with the right resource support (staff and equipment) including:

(a) The degree to which appropriate care is available to meet the patient's needs given the current state of knowledge.

(b) The degree to which the care is provided to the patient at the most beneficial or necessary time.

(c) The degree to which the care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome for the patient.

(d) The degree to which the care for the patient is coordinated among practitioners and organizations over time.

(e) The degree to which the risk of an intervention in the care environment is reduced for the patient and others, including the health care provider.

(f) The relationship between the outcomes and results of patient care and the resources used to deliver care.

(g) The degree to which the patient or designee is involved in his or her own care decisions and to which those providing services do so with sensitivity and respect for the patient's needs, expectations, and individual differences.

c. The Improvement Cycle. The improvement of system performance is a cyclic process based on the recognition that better patient outcomes will result by improving the business and clinical processes (knowledge base and staff skills) related to the outcomes. The components of the improvement cycle, such as processes, data, and opportunities, are linked by the activities of the organization's leaders, manager, and staff who plan, measure, assess, and improve their daily work processes.

d. Additional Important Patient Care Functions. Must include the following (see enclosure (2) for detailed guidance):

- (1) Operative, other invasive or noninvasive procedures.
- (2) Medication use.
- (3) Blood and blood components' use.
- (4) Medical record review.
- (5) Postmortem examinations.

e. Risk Management. Risk management activities, per reference (j), related to the clinical aspects of patient care and safety are:

- (1) Identification of general areas of potential risk such as supervision of interns and residents.
- (2) Development of criteria for identifying specific cases with potential high risk and evaluation of these cases.
- (3) Correction of problems and their root cause identified by risk management activities.
- (4) Design of programs to proactively identify and reduce risk, i.e., building reliability.
- (5) Annual risk management education and training for medical staff.

f. Utilization Management (UM). The medical staff must participate in UM activities. UM is an organized, comprehensive approach to analyze, direct, and conserve organizational resources with a view towards providing care that is both efficient and cost effective. Data from UM activities help to establish practice patterns that may have a direct impact on the quality of health care delivered. Inpatient, as well as outpatient, procedures and services are included in UM. The local MTF UM instruction or policy and procedure can delineate what functions are reviewed, based on the scope of care and services at the facility. (See reference (l) for UM guidance and activities.)

g. Other Review Functions

- (1) The medical staff must participate in other facility-wide review functions, including infection control, safety, and internal and external disaster planning.
- (2) Concerning postmortem examinations, the medical staff, in cooperation with other appropriate facility clinical support staff, must develop and use criteria published in local MTF policies and procedures that:

- (a) Identify deaths in which an autopsy should be performed.
- (b) Establish mechanisms for documenting permission to perform an autopsy.
- (c) Establish a system for notifying the medical staff, specifically the attending practitioner, when an autopsy is being performed. The medical staff will attempt to secure autopsies in all deaths that meet the criteria for autopsies. Findings from autopsies must be used as a source of clinical information in QM activities.

9. Education. All individuals with a medical staff appointment having delineated clinical privileges must participate in continuing education activities that relate primarily to the privileges granted.

a. MTF-sponsored educational activities must be offered and relate primarily to:

- (1) Type and nature of care offered by the facility.
- (2) Findings of QM activities.
- (3) Results of accreditation and medical inspector general surveys.
- (4) Expressed educational needs of individuals with clinical privileges.

b. Each practitioner's participation in continuing professional education must be documented and considered at the time of reappointment to the professional staff or renewal or revision of individual clinical privileges.

10. Supplemental MTF Policies and Procedures, to comply with the requirements of this instruction, must be developed by the medical staff and approved by the privileging authority. Use the outline in enclosure (2) as a guide.

11. Amendments. Proposed amendments to these DON medical staff bylaws may be submitted for consideration at any time via the chain of command to: Chief, Bureau of Medicine and Surgery (BUMED-M3M), 2300 E Street NW, Washington, DC 20372-5300.

12. Annual Review. These bylaws shall be reviewed annually by BUMED-M3M. Supplemental MTF medical staff policies and procedures must be reviewed annually as part of the MTF's QM program annual assessment. Revisions of supplemental MTF medical staff policies and procedures must be made to reflect current practices with respect to medical staff organization and function and compliance with references (b) through (g).

NAVAL MEDICAL DEPARTMENT
FACILITY-SPECIFIC MEDICAL STAFF POLICIES AND PROCEDURES

SUGGESTED OUTLINE

1. General. Enter a general statement of effective date, to whom rules and regulations are applicable, and who will perform orientation of new applicants. Include mechanism for changing the MTF-specific local medical staff policies and procedures.
2. Local Medical Staff. Describe local medical staff policies and procedures if there is a need to tailor enclosure (1) provisions to local staff. Making reference to a local instruction is acceptable, if this matter is addressed therein, rather than restating existing guidance.
3. Medical Staff Appointment and Reappointment. Describe appointment and reappointment policies and procedures if there is a need to tailor enclosure (1) provisions to local staff. Include local procedure for handling applications as well as those for privilege modifications. Making reference to a local instruction is acceptable, if these matters are addressed therein, rather than restating existing guidance.
4. Delineated Clinical Privileges. Describe privilege policies and procedures if there is need to tailor enclosure (1) provisions to local staff. Include any command policies with respect to the practice of core privileges due to facility, equipment, staff, or other constraints. Describe the scope of services provided in the facility (e.g., inpatient, outpatient, level III emergency medicine, obstetrics, orthopedics, and general surgery). These restrictions will not categorically restrict the scope of practice for a given type of practitioner. Any restrictions will reflect facility resource constraints (e.g., supplies, training, and availability of comprehensive patient care support throughout the entire care continuum) or individual practitioner education, experience, or competence. Each clinical department will have, as part of their policies and procedures, a list of departmental-specific criteria for the granting of privileges, including any practice restrictions and the department's scope of clinical services. Referencing a local instruction is acceptable, if these matters are addressed therein, rather than restating existing guidance. MTF policies and procedures will delineate the process for referral or transfer of patients in circumstances in which required services are not provided by the facility, for example, emotional illness or substance abuse.
5. Local Medical Staff Organization. Describe how the medical staff is organized (at the directorate, department, division, or facility-wide level); describe how the important functions of medication use, blood use, and operative and other invasive procedures are measured, assessed, and improved (e.g., committee, individual department, or other methods); describe composition of ECOMS and frequency of meetings; note whether or not a credentials review committee exists; and note the frequency of medical staff meetings, if not annually, describe mechanisms of medical staff communication throughout the chain of command. Include a list of all departments in which surgical or other invasive procedures are provided. Include a list of all departments or areas where medications are administered for analgesia and sedation, to include moderate

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sedation and analgesia (conscious sedation/analgesia), outside the operating room by non-anesthesia personnel. Referencing a local instruction is acceptable, if these matters are addressed therein, rather than restating existing guidance.

a. Each MTF shall establish local policies and procedures that include a description of medical staff officer positions, method of electing officers, qualifications, responsibilities, tenure of officers, and the conditions and mechanisms for removing officers from their positions. All officers of the medical staff, including committee chairs, must be members of the medical staff and must be appointed by the commanding officer or elected by the medical staff. The ECOMS makes appointment recommendations regarding office candidates to the commanding officer, who has final decision authority. The commanding officer may remove any appointed or elected officer or chair in a "show cause" or per paragraph 6a(3) of enclosure (1). At least one member will be elected to the ECOMS by the medical staff.

b. In facilities with medical staff departments, MTF local policies and procedures must specify a meeting frequency for clinical departments, no less than quarterly, at which time the findings of QM activities will be assessed.

c. When there are no medical staff departments, MTFs will have local policies and procedures to address the medical staff mechanisms for the recommendation of privileges and QM activities involving quality of care review for all individuals with clinical privileges. In clinical departments with a nonphysician department head, monitoring of clinical competency and staff appointment and privileging issues should include review by the appropriate professional specialty.

d. Each MTF shall establish local policies and procedures describing the mechanism of communication between the ECOMS and the medical staff. This policy must address the process by which the medical staff participates in the decisions made by the organization related to patient and medical care issues. See subparagraphs 6a(1) through 6a(7) of enclosure (1).

6. Supervision Issues

a. Supervision of House Staff. In facilities participating in professional graduate education programs, clinical supervision of house staff by medical staff members must be stated, in writing, either on a watch list or in the patient's medical record and without restriction of the medical staff member's authority to write orders. The denial or limitation of privileges of medical staff members who choose not to participate in the teaching program is prohibited.

b. Supervision of Unlicensed Practitioners. See reference (e).

c. Supervision of Nonindependent Practitioners. See reference (e).

7. Multidisciplinary Treatment Plans. Address multidisciplinary treatment plans and ensure appropriate physician involvement in their approval when an MTF that has a psychiatric or substance abuse department determines that such plans are appropriate.

8. Other Local Policies and Procedures. Develop local policies and procedures with respect to optional matters such as, requested residential proximity to the facility for medical staff, watches and provisions for medical staff backup, use of subjective-objective-assessment-plan-instructions (SOAPI) format in charts, required frequency of progress note and supervisory annotation in inpatient charts, scope of care for students and the method of supervision of trainees, and consultation and referral procedures or rules. A list of local instructions pertinent to medical staff functions may be included, e.g., QM Program, credentials review and privileging, medical records, patient's bill of rights, and risk management.

9. Emergency Care. MTFs providing only ambulatory care services, accredited under reference (c), must address the provision of urgent care services. The availability of emergency services is required for all facilities accredited under reference (b), regardless of whether ambulatory care is provided. In both areas, emphasis is on providing the appropriate services based on customer/patient population needs. Defined means of access and transportation to appropriate emergency care, internal and external, must be included.

10. Annual Review. MTFs will develop a provision for annual review.

11. Special Treatment Procedures. MTFs will develop local policies and procedures to provide guidance on the use of special treatment procedures following guidance included in enclosure (3) of these bylaws.

12. Important Functions. The medical staff provides leadership for the process measurement, assessment, and improvement of the following functions:

a. Operative, Other Invasive and Noninvasive Procedures

(1) Multidisciplinary Collaboration. Measurement, assessment, and improvement of operative, other invasive and noninvasive procedures must be performed in a collaborative and multidisciplinary environment, including all individuals and professions involved in providing these services. The medical staff must play a central role in this process and is responsible when the review focuses on the performance of privileged practitioners.

(2) Priorities for Measurement. Each MTF must prioritize its operative, other invasive and noninvasive procedures, selecting high priority procedures or categories of procedures for measurement. The variety of procedures measured must be representative of the organization's scope of care and priorities. For each category chosen, the sample of cases selected for measurement must be statistically representative.

(3) Focus on Processes. Measurement must include the processes related to:

(a) Selecting appropriate procedures.

(b) Preparing patients for procedures.

- (c) Performing procedures and monitoring patients.
- (d) Providing post-procedure care.
- (e) Performing post-procedure patient education.

It is not required to measure all five processes for each procedure selected, however, all these processes must be included in the organization's overall measurement of operative, other invasive and noninvasive procedures. The goal of this activity is measurement of the performance in an area, over a period of time, to understand process variation (rather than time-limited, focused studies).

(4) Diagnostic Discrepancies (Performance Variance Measures). An intensive assessment must be initiated in response to all major discrepancies or patterns of discrepancies such as, between preoperative and postoperative (or pathologic) diagnoses, and adverse events or patterns of adverse events during anesthesia use.

(5) Frequency of Measurement, Assessment, and Reporting. Measurement must be an ongoing process. Assessment and reporting frequency must be at least quarterly.

b. Medication Use

(1) Multidisciplinary Collaboration. Measurement, assessment, and improvement of medication use must be performed in a collaborative and multidisciplinary environment, including pharmacy staff, nursing staff, management and administrative staff, medical staff, and others as needed. The medical staff must play a central role in this process and is responsible when the review focuses on the performance of privileged practitioners.

(2) Measurement Priorities. Each MTF will establish measurement priorities for its medication use. The variety of medications measured must be representative of the organization's scope of care and higher priorities. For each medication or category of medication chosen for measurement, the sample of cases selected must be statistically representative.

(3) Process Focus. Measurement must include the processes related to:

- (a) Prescribing and ordering.
- (b) Preparing and dispensing.
- (c) Administering.
- (d) Monitoring the effects of medications on patients.

It is not required to measure all four processes for each medication selected, however, all four processes must be included in the organization's overall measurement of medication use. The goal of this activity is measurement of the performance in an area, over a period of time, to understand process variation (rather than time-limited, focused studies).

(4) Adverse Drug Reactions (Performance Variance Measures). MTF local policies and procedures must include a definition of a significant adverse drug reaction (ADR) as well as a procedure to obtain data regarding its occurrence. All significant ADRs must receive intensive assessment.

(5) Measurement, Assessment, and Reporting Frequency. While measurement is an ongoing process, assessment and reporting frequency must be at least quarterly.

(6) Drug Formulary Maintenance. MTFs will develop local policies and procedures to address maintenance of the drug formulary.

(7) Investigational and Experimental Drugs. MTFs will develop local policies and procedures to address approval of protocols that use investigational and experimental drugs.

(8) Medication Errors. MTFs will develop local policies and procedures that define processes to measure and assess organizational performance on medication errors.

c. Blood and Blood Components Use

(1) Multidisciplinary Collaboration. Measurement, assessment, and improvement blood and blood components' use must be performed in a collaborative and multidisciplinary environment, including all individuals and professions involved in providing this service. The medical staff must play a central role in this process and is responsible when the review focuses on the performance of an LIP clinical privilege.

(2) Measurement Priorities. Each MTF will establish measurement priorities of its blood and blood components' use. The variety of blood components measured must be representative of the organization's scope of care and higher priorities. For each blood component chosen for measurement, the sample of cases selected must be statistically representative.

(3) Process Focus. Measurement must include the processes related to :

- (a) Ordering.
- (b) Distributing, handling, and dispensing.
- (c) Administering.
- (d) Monitoring the effects of blood and blood components on patients.

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It is not required to measure all four processes for each component selected, however, all four processes must be included in the organization's overall measurement of blood and blood components' use. The goal of this activity is measurement of performance in an area, over a period of time, to understand process variation (rather than time-limited, focused studies).

(4) Transfusion Reactions (Performance Variance Measures). MTFs will develop local policies and procedures that define the criteria to identify transfusion reactions. All confirmed transfusion reactions must receive intensive assessment.

(5) Measurement, Assessment, and Reporting Frequency. While measurement is an ongoing process, assessment and reporting frequency must be at least quarterly.

d. Medical Record Review

(1) Multidisciplinary Collaboration. Medical record review must be performed in a collaborative, multidepartmental environment by the medical staff, nursing staff, the medical records department, management and administrative services, and representatives of other departments as appropriate. The medical staff must play a central role in this process. The medical staff is responsible when the review focuses on the performance of an LIP with clinical privileges. The medical staff must additionally be involved in the review of medical records to evaluate the quality of the records themselves, e.g., clinical pertinence reviews. One purpose of the medical record review is to improve the quality and usefulness of the medical record for making decisions regarding patient care.

(2) Focus of Measurement. Each medical record or a representative sample of medical records must contain the items listed in references (b) and (c). MTF policies and procedures must define the sampling rate and methodology. Inpatient medical records must be completed within 30 days.

(3) Measurement, Assessment, and Reporting Frequency. The completeness, accuracy, and timely completion of information in medical records must be reviewed and documented at least quarterly.

13. General Medical Record Requirements

a. A medical record must be initiated and maintained for each individual assessed or treated in all areas of the MTF including inpatient, emergency department, and ambulatory care.

b. No medical record will be removed from the MTF's jurisdiction and safekeeping without a court order or subpoena, except as required by law and per references (i) and (k).

c. MTFs will develop local policies and procedures specifying the categories of individuals who are authorized to make entries in medical records.

d. MTFs will develop local policies and procedures on the use of verbal orders: how, when, who may accept them, time period for authentication, and definition of diagnostic or therapeutic verbal orders associated with potential hazard to the patient.

e. MTFs will develop local policies and procedures defining the requirements for counter-signature of medical record entries prepared by clinical support staff and nonprivileged practitioners. These policies and procedures must be within the guidelines of relevant DOD, DON, and BUMED instructions.

f. Each medical record must contain the data elements listed in references (b) and (c) to identify the patient, support the diagnosis, justify the treatment, document the course and results, and facilitate continuity of care among health care providers.

g. All patients admitted for inpatient care must have a history taken and a comprehensive physical examination performed within 24 hours of admission by a physician, a member of the medical staff with clinical privileges, or by a nonphysician member of the medical staff with appropriate admitting privileges.

(1) Qualified oral and maxillofacial surgeons who admit patients without medical problems may perform the history and physical examination on these patients, if they have such privileges and may assess the medical risks of proposed surgical procedures.

(2) Other individuals who are permitted to provide patient care services independently may perform the history and physical examination, if granted such privileges. The findings, conclusions, and assessment of risk are confirmed or endorsed by a qualified physician before major high-risk (as defined by the local medical staff), diagnostic, or therapeutic interventions are performed.

(3) Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry.

(4) Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry.

h. For patients receiving ambulatory care services, the medical record must include a summary list (see references (b), (c), and (i) for specific guidance), containing a summary of known significant diagnoses, conditions, procedures, drug allergies, and current medications. The summary list is to be initiated and maintained for each patient seen for continuing ambulatory care.

14. Postmortem Examinations. The medical staff, in cooperation with other appropriate facility clinical support staff, must develop and use criteria published in local MTF policies and procedures that:

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- a. Identify deaths in which an autopsy should be performed.
- b. Establish mechanisms for documenting permission to perform an autopsy.
- c. Establish a system for notifying the medical staff, specifically the attending practitioner, when an autopsy is being performed. The medical staff will attempt to secure autopsies in all deaths that meet the criteria for them. Findings from autopsies must be used as a source of clinical information in QM activities.

NAVAL MEDICAL DEPARTMENT
FACILITY-SPECIFIC MEDICAL STAFF POLICIES AND PROCEDURES FOR
RESTRAINT AND SECLUSION

SUGGESTED OUTLINE

1. Special Treatment Procedures. Restraint and seclusion is limited to emergencies in which there is an imminent risk of an individual physically harming him or herself, staff, or others and when nonphysical interventions are not appropriate. MTFs will develop local policies and procedures to provide guidance on the use of special treatment procedures, e.g., special interventions in all areas of the facility. Medical staff must take special precautions to ensure these interventions are warranted and do not endanger patients.

a. Restraint or Seclusion for Behavioral Health Patients. For emergent situations requiring immediate use of restraint or seclusion, specific staff as designated in the MTF policies and procedures may initiate restraint or seclusion and then obtain a physician's verbal or written order. In all areas of the facility with a psychiatric unit or clinic, a physician's verbal or written order must be obtained within 1 hour of the initial use of restraint or seclusion. The use of "as needed" (PRN) orders, whether individual or as part of a protocol, for patients with primary behavioral health needs is prohibited. In all areas of the MTF whenever a verbal order is given for restraint or seclusion, a written order must be placed in the patient's medical record within 24 hours. If a patient requires over 72 hours of continuous restraint or seclusion or more than four separate episodes within a 7-day period, a special meeting of the treatment team or conference between the responsible physician and the nursing team will be held to consider alternative approaches. MTFs will develop local policies and procedures to address the following:

(1) Medical staff must approve the use of restraint and seclusion as an integral component of medical, dental, diagnostic, or surgical procedures or devices in all areas of the MTF. The restraint and seclusion standards for behavioral health care patients do not apply to standard practices that include limitation of mobility or temporary immobilization related to medical, diagnostic, or surgical procedures and related post-procedure care processes, e.g., surgical positioning, intravenous arm boards, etc.).

(2) Definitions of restraint and seclusion and the physical areas in the command where restraint and seclusion may be used.

(3) Requirement for the medical record to contain appropriate clinical justification to explain emergency situation, time-limitation, and complete documentation of each use of restraint or seclusion.

(4) Qualifications of staff members who may initiate or terminate restraint or seclusion.

(5) Requirements for the periodic observation of the patient, attention to the needs of the patient and documentation thereof, including the maximum length of time between observations

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of the patient in restraint or seclusion (never greater than 15 minutes). For behavioral health care provided to patients, the monitoring frequency will be continuous or no less frequent than every 15 minutes. The documentation of the observation must include at least the following: vital signs, noting relevance to the physical safety of the patient's nutritional and hydration needs; circulation and range of motion of extremities; hygiene; elimination; physical and psychological status and comfort; assistance enabling individual to meet behavioral criteria for discontinuation of restraint or seclusion; readiness for discontinuation of restraint or seclusion; a need for LIP or emergency medical services.

(6) Specification of the maximum amount of time for the use of restraint or seclusion.

Written orders for restraint or seclusion are limited to: 24 hours; 4 hours for adults with a primary behavioral health need, 2 hours for children and adolescents ages 9 to 17 with primary behavioral health needs; or 1 hour for patients under age 9 with primary behavioral health needs. The above must be written in the original order.

(7) After the original order has expired, an LIP must conduct a face-to-face (personal) evaluation of an individual. For hospitals that use accreditation for Medicare deemed status with the JCAHO, the standard is an LIP must conduct a face-to-face (personal) evaluation of an individual in restraint and seclusion, regardless of age, within 1 hour of the initiation of restraint or seclusion.

(8) After the initial time-limited order expires, the LIP must write a new order if restraint or seclusion is continued. The original order and the command's policy may permit a licensed, qualified, and authorized health care provider, e.g., registered nurse, to perform the reassessment and make a decision to continue the original order for an additional: 4 hours for adults up to a maximum of 24 hours; 2 hours for children and adolescents ages 9 to 17 up to a maximum of 24 hours; or, 1 hour for children under age of 9 for periods up to a maximum of 24 hours, but an LIP must write the order and be notified of the individual's status if the restraint or seclusion is continued.

(9) Identification of patient categories at risk to be placed in restraint or seclusion.

(10) Methods to continuously decrease the use of restraints throughout the facility.

(11) Procedures for the early release of patients from restraint or seclusion.

b. Restraint or Seclusion for Acute Medical and Surgical (Nonpsychiatric) Care. These policies address use of restraint in care of medical and surgical patients, which includes patients receiving pediatric, obstetric, or rehabilitation care in areas other than a psychiatric unit. The MTF will develop local policies and procedures to address the following:

(1) Restraints that limits the use to situations where there is appropriate clinical justification. For specified conditions or procedures, protocols for the use of restraint must be established.

(2) Identification of performance improvement processes to seek opportunities to reduce the risks associated with restraint through the use of preventive strategies and innovative alternatives.

(3) Acute medical or surgical patient restraint is used pursuant to either an individual order or an approved protocol within the command. Restraint is used upon order of an LIP. If such a practitioner is not available, a registered nurse may initiate restraint use based on appropriate assessment of the patient. An LIP must be notified within 12 hours of initiation of restraint, and a verbal or written order must be obtained; verbal orders must be signed within 24 hours.

(4) Requirements for the periodic observation of the patient. A patient in restraints must, at a minimum, be monitored every 15 minutes through observation or interaction to determine the physical and emotional well-being of the patient, obtain vital signs, nutrition and hydration status, hygiene and elimination needs, maintenance of the patient's rights and dignity, whether less restrictive methods are possible, changes in patient's behavior or clinical condition needed to remove restraints, and whether restraint has been appropriately applied, removed or reapplied.

(5) Requirements for appropriate documentation in patient's medical record for each restraint episode.

c. Electroconvulsive and Other Forms of Convulsive Therapy. Complete the following before initiating electroconvulsive therapy for a child or adolescent:

(1) Two qualified child psychiatrists with training or experience in the treatment of children or adolescents must examine the patient.

(2) The examining psychiatrists cannot be directly involved in the treatment of the patient.

(3) The examining psychiatrists must provide their findings and assessments in writing to the primary treating psychiatrist.

(4) The patient's medical record must reflect the examining psychiatrists' concurrence with the decision to administer such therapy.

d. Psychosurgery or Other Surgical Procedures to Alter or Intervene in an Emotional, Mental, or Behavioral Disorder. Local policies and procedures must address:

(1) Indications for use.

(2) Requirements for documentation of these procedures in the patient's medical record, including justification for use of the procedure.

e. Behavior-Management Procedures that Use Biofeedback, Reinforcement, or Aversive Therapy. MTFs that perform these procedures must develop local policies and procedures that address:

- (1) Staff qualifications.
- (2) Selection criteria for patients.
- (3) Documentation of these procedures in the patient's medical record, including justification for their use.

f. Substance Abuse Services. When an MTF has substance abuse services, admission and discharge privileges are as follows:

- (1) If a clinical psychologist is department head, then a physician assigned to the alcohol rehabilitation department (ARD) must perform the admission physical examination.
- (2) If no physician is assigned to the ARD, the admission physical must be provided by another physician assigned to the MTF.
- (3) If a physician other than a psychiatrist is the ARD head, a psychiatrist or clinical psychologist must perform the psychosocial evaluation of ARD patients.
- (4) If no psychiatrist or clinical psychologist is assigned to the ARD, a psychiatrist or clinical psychologist assigned to the MTF must perform the psychosocial evaluation of ARD patients.